Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

IRVING COPPELL SURGICAL HOSPITAL
440 WEST INTERSTATE 635
IRVING TX 75063

Respondent Name
LIBERTY MUTUAL FIRE INSURANCE COMPANY

Carrier's Austin Representative Box
Box Number 1

MFDR Tracking Number
M4-09-B134-01

MFDR Date Received
August 5, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Not paid at 200% APC Appeal filed to carrier; upheld original decision"

Amount in Dispute: $9,798.65

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CPT 264145 is not documented in the operative report and was correctly denied. . . . The bill was not correctly coded per the procedures performed on the operative report."

Response Submitted by: Liberty Mutual, 2875 Browns Bridge Road, Gainesville, Georgia 30504

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
March 13, 2009	Outpatient Hospital Services	$9,798.65	$9,777.39

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
4. 28 Texas Administrative Code §133.4 requires written notification to health care providers regarding contractual agreements for informal and voluntary networks.

5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - X936 – CPT OR HCPC IS REQUIRED TO DETERMINE IF SERVICES ARE PAYABLE. (X936)
   - Z547 – THIS BILL WAS REVIEWED IN ACCORDANCE WITH YOUR FEE FOR SERVICE CONTRACT WITH FIRST HEALTH. FOR QUESTIONS REGARDING THIS ANALYSIS PLEASE CALL (800) 937-6824. THIS REIMBURSEMENT MAY REFLECT PAYMENT AT RATES LESS THAN YOUR DISCOUNTED CONTRACT RATE IN ACCORDANCE WITH YOUR PPO NETWORK CONTACT AND OUR ACCESS AGREEMENT WITH THEM. (Z547)
   - P303 – THIS SERVICE WAS REVIEWED IN ACCORDANCE WITH YOUR CONTRACT. (P303)
   - U849 – THIS MULTIPLE PROCEDURE WAS REDUCED 50%% ACCORDING TO FEE SCHEDULE OR USUAL AND CUSTOMARY GUIDELINES. (U849)
   - Z652 – RECOMMENDATION OF PAYMENT HAS BEEN BASED ON A PROCEDURE CODE WHICH BEST DESCRIBES SERVICES RENDERED. (Z652)
   - Z710 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE. (Z710)
   - Z346 – RIGHT SIDE. (Z346)
   - X901 – DOCUMENTATION DOES NOT SUPPORT LEVEL OF SERVICE BILLED. (X901)
   - X668 – VENIPUNCTURE CHARGES ARE INCLUDED IN THE GLOBAL LAB FEES. (X668)

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. Does the documentation for procedures billed under code 26415 support the level of services billed?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. What is the recommended payment amount for the services in dispute?
5. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reason code P303 – "THIS SERVICE WAS REVIEWED IN ACCORDANCE WITH YOUR CONTRACT," and Z547 – "THIS BILL WAS REVIEWED IN ACCORDANCE WITH YOUR FEE FOR SERVICE CONTRACT WITH FIRST HEALTH. FOR QUESTIONS REGARDING THIS ANALYSIS PLEASE CALL (800) 937-6824. THIS REIMBURSEMENT MAY REFLECT PAYMENT AT RATES LESS THAN YOUR DISCOUNTED CONTRACT RATE IN ACCORDANCE WITH YOUR PPO NETWORK CONTACT AND OUR ACCESS AGREEMENT WITH THEM." Review of the submitted information found insufficient documentation to support that the disputed services were subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on October 14, 2010, the Division requested the respondent to provide a copy of the referenced contract as well as documentation to support notification to the healthcare provider, as required by 28 Texas Administrative Code §133.4, that the insurance carrier had been given access to the contracted fee arrangement. Review of the submitted information finds that the documentation does not support notification to the healthcare provider in the time and manner required.
   - The purported notification documentation does not contain the necessary contact information for the network including the name, the physical address of the network, and a toll-free telephone number accessible to all contracted health care providers as required by §133.4(d)(1).
   - The purported notification documentation does not include the name, physical address, and telephone number of the insurance carrier or any person given access to the network's fee arrangement with the health care provider as required by §133.4(d)(2)(A).
   - No documentation was found to support timely notice to the health care provider in accordance with the requirements of §133.4(f)(1), which requires that "for contracts with health care providers in effect on August 1, 2008, initial notification must be made no later than November 1, 2008, and subsequent notices provided to health care providers in accordance with this section thereafter on a quarterly basis."
   - No documentation of the initial notification was found in the submitted materials.
   - No documentation of any quarterly update was found in the submitted materials.
   - The respondent provided a copy of a network payor listed dated April 11, 2006.
   - The date of the payor list predates the effective date of §133.4.
   - The name of the insurance carrier, Liberty Mutual Fire Insurance Co., is not listed on the submitted payor list.
   - Page 23, section 6.16 of the submitted contract contains specific language regarding when notices shall be deemed to have been duly given, made and received.
   - No documentation was found to support that notice was duly given, made and received in accordance with the terms of the contract sought to be applied to the services in dispute.

   Accordingly, the Division concludes that, pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.

2. The insurance carrier denied disputed services billed with procedure code 26415, which denotes a "Synovectomy, tendon sheath, radical (tenosynovectomy), flexor tendon, palm and/or finger, each tendon." The provider reported 8 units, with modifiers F6, F7, F8, and F9, indicating 2 units each performed on the second, third, fourth and fifth digits of the right hand. The respondent denied the services with reason code X901 – "DOCUMENTATION DOES NOT SUPPORT LEVEL OF SERVICE BILLED." The respondent's position statement asserts that "CPT 26414 is not documented in the operative report and was correctly denied." Review of the operative report finds that the provider documented synovectomies performed on eight tendons including the flexor profundus tendons and flexor sublimis tendons to the index, middle, ring and little fingers of the right hand. The Division finds that the medical documentation supports the services as billed. The Division concludes that the insurance carrier's denial reason is not supported; therefore, the services will be reviewed for payment according to applicable rules and fee guidelines.

3. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.

4. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:

   - Procedure code 25105 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 0050, which, per OPPS Addendum A, has a payment rate of $1,973.95. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,184.37. This amount multiplied by the annual wage index for this facility of 0.9816 yields an adjusted labor-related amount of $1,162.58. The non-labor related portion is 40% of the APC rate or $789.58. The sum of the labor and non-labor related amounts is $1,952.16. The cost of these services does not exceed the annual fixed-dollar threshold of $1,800. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $1,952.16. This amount multiplied by 200% yields a MAR of $3,904.32.
   - Procedure code 14020 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. These services are classified under APC 0136, which, per OPPS Addendum A, has a payment rate of $1,055.29. This amount multiplied by 60% yields an unadjusted labor-related amount of $633.17. This amount multiplied by the annual wage index for this facility of 0.9816 yields an adjusted labor-related amount of $621.52. The non-labor related portion is 40% of the APC rate or $422.12. The sum of the labor and non-labor related amounts is $1,043.64. The cost of these services does not exceed the annual fixed-dollar threshold of $1,800. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line, including multiple-procedure discount, is $521.82. This amount multiplied by 200% yields a MAR of $1,043.64.
   - Procedure code 26145 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. These services are classified under APC 0053, which, per OPPS Addendum A, has a payment rate of $1,097.38. This amount multiplied by 60% yields an unadjusted labor-related amount of $658.43. This amount multiplied by the annual wage index for this facility of 0.9816 yields an adjusted labor-related amount of $646.31. The non-labor related portion is 40% of the APC rate or $438.95. The sum of the labor and non-labor related amounts is $1,085.26. The cost of these services does not exceed the annual fixed-dollar threshold of $1,800. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line, including multiple-procedure discount, is $542.63. This amount multiplied by 200% yields a MAR of $1,085.26.

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procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. These services are classified under APC 0053, which, per OPPS Addendum A, has a payment rate of $1,097.38. This amount multiplied by 60% yields an unadjusted labor-related amount of $658.43. This amount multiplied by the annual wage index for this facility of 0.9816 yields an adjusted labor-related amount of $646.31. The non-labor related portion is 40% of the APC rate or $438.95. The sum of the labor and non-labor related amounts is $1,085.26. The cost of these services does not exceed the annual fixed-dollar threshold of $1,800. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line, including multiple-procedure discount, is $542.63. This amount multiplied by 200% yields a MAR of $1,085.26.

- Procedure code 64719 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. These services are classified under APC 0220, which, per OPPS Addendum A, has a payment rate of $1,222.81. This amount multiplied by 60% yields an unadjusted labor-related amount of $733.69. This amount multiplied by the annual wage index for this facility of 0.9816 yields an adjusted labor-related amount of $720.19. The non-labor related portion is 40% of the APC rate or $489.12. The sum of the labor and non-labor related amounts is $1,209.31. The cost of these services does not exceed the annual fixed-dollar threshold of $1,800. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line, including multiple-procedure discount, is $604.66. This amount multiplied by 200% yields a MAR of $1,209.32.
- Procedure code 36415 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $3.00. 125% of this amount is $3.75
- Procedure code 80047 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $12.36. 125% of this amount is $15.45
- Procedure code 85014 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $3.46. 125% of this amount is $4.33
- Procedure code 82948 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $4.63. 125% of this amount is $5.79
- Procedure code 81025 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $9.24. 125% of this amount is $11.55
- Procedure code 81002 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $3.74. 125% of this amount is $4.68

- Procedure code 82803 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $28.25. 125% of this amount is $35.31
- Procedure code 73110 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0260, which, per OPPS Addendum A, has a payment rate of $44.70. This amount multiplied by 60% yields an unadjusted labor-related amount of $26.82. This amount multiplied by the annual wage index for this facility of 0.9816 yields an adjusted labor-related amount of $26.33. The non-labor related portion is 40% of the APC rate or $17.88. The sum of the labor and non-labor related amounts is $44.21. The cost of these services does not exceed the annual fixed-dollar threshold of $1,800. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $44.21. This amount multiplied by 200% yields a MAR of $88.42.

5. The total allowable reimbursement for the services in dispute is $15,008.64. This amount less the amount previously paid by the insurance carrier of $5,231.25 leaves an amount due to the requestor of $9,777.39. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $9,777.39.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $9,777.39, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	June 28, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.